



## Arkansas FFA Association

### Student Emergency Contact Form

*Student Must Have a Completed Form on File In Order To Participate in Arkansas FFA Association Activities*  
*Please Type or Print Plainly*

We understand that medical and/or hospital care will be available and provided if an illness and/or injury develops, and that we will be notified as soon as possible in such instance. We do hereby authorize the State FFA Advisor and/or State FFA Executive Secretary or their designate to provide and/or secure any emergency treatment which may become necessary while our son/daughter is being transported to/from or in attendance at activities of the Arkansas FFA Association. We are providing our medical insurance information and will be responsible for all necessary expenses in regards to the provision of said emergency treatment. We hereby release the Arkansas FFA Association, State FFA Advisor, State FFA Executive Secretary, FFA Camp Couchdale, and their designates from any liability in regards to emergency treatment rendered to our son/daughter while in attendance at activities of the Arkansas FFA Association. We understand and accept the above statement by our signatures below:

Student Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

FFA Chapter: \_\_\_\_\_ Chapter Phone: (\_\_\_\_) \_\_\_\_\_

Advisor: \_\_\_\_\_ Chaperone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Guardian / Mother: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Guardian / Father: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please list any health concerns that the conference staff needs to be aware of: asthma\_\_\_\_, heart condition\_\_\_\_, convulsions\_\_\_\_, diabetes\_\_\_\_, fainting spells\_\_\_\_, menstrual problems\_\_\_\_, migraines\_\_\_\_. Allergies: food (please list)\_\_\_\_ insect bites\_\_\_\_, bee stings\_\_\_\_, poison ivy/oak\_\_\_\_, Drug Allergies/Reactions: Penicillin\_\_\_\_, aspirin\_\_\_\_, other (please list)\_\_\_\_  
Date of last tetanus immunization\_\_\_\_, tetanus antitoxin\_\_\_\_, tetanus toxoid\_\_\_\_, measles booster\_\_\_\_

Please list any specific activities to be restricted: \_\_\_\_\_

Policy of student's home school district will be followed in regards to use of any medications while student is in transit to/from and attending Arkansas FFA Association activities. Please list any prescription or non-prescription medication that your student may be using: \_\_\_\_\_

### **Parent/Guardian Authorization Statement: Must Be Signed By Parent Or Guardian**

Guardian/Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian/Father's Signature: \_\_\_\_\_ Date: \_\_\_\_\_